State of Idaho Emergency Medical Services Bureau

Provider Application Form

Level Applied For: ☐ First Responder ☐ EMT-Basic ☐ Advanced EMT-A ☐ EMT-Paramedic

Type: ☐ Initial ☐ Recertification ☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity

Applicant Information:

Social Security # ___ - __ - ___ Date of Birth __ / __ / __ Drivers License # _____ DL State ___

Name _____ Gender ☐ F ☐ M

Last Name First Name Middle Name/Initial

Mailing Address _____

City _____ State _____ Zip _____ County _____

Home Phone # _____ Work Phone # _____ E-Mail _____

Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

Affiliation:

Agency Name _____ Agency License # _____

Agency Chief/Director/President _____ _____

Signature Printed Name

Additional Licensed EMS Affiliations: _____

Check all circumstances in which you will use this certification: *Volunteer* *Career*

☐ True ☐ Full Time

☐ Compensated ☐ Part Time

Applicant Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.

_____ _____

Signature of Applicant Date signed

For Bureau Use Only

Original Date Received in RO		Original Date Received in C&L	
	CHC Scan Date (PROV) _____ CHC Complete Date (FULL) _____ Course # _____ NR Written Date _____ NR Practical Date _____ Ambulance Rating (if AEMTA) Date _____ Included☐		**FR/BASIC** **Test Date:** **Expiration:** 06/01-11/01 12/31/2004 12/01-05/02 06/30/2005 06/02-11/02 12/31/2005 12/02-05/03 06/30/2006 06/03-11/03 12/31/2006 12/03-05/04 06/30/2007 06/04-11/04 12/31/2007 12/04-05/05 06/30/2008 06/05-11/05 12/31/2008 12/05-05/06 06/30/2009 **ADV/PAR** **Test Date:** **Expiration:** 12/01-11/02 06/30/2004 12/02-11/03 06/30/2005 12/03-11/04 06/30/2006 12/04-11/05 06/30/2007 12/05-11/06 06/30/2008
Received in RO Complete	Cert. Fee Rcvd Date_____ Approval Date/Initial _____ Entered into Database _____ _____ Date Sent to CO _____ Previous ID State Certification ☐ _____	Received in C&L Complete	

Revised 01/21/04

EMT-Paramedic **Applicant Name:** _____

❑ **$25 Recertification Fee**

Recertification Education Record

Record the number of hours accumulated during the current certification period in each category based on the method utilized. Total all hours across and down.

Assurance of Knowledge Categories	Classroom Sessions	Refresher Program	Nationally Recognized Courses	Regional and National Conferences	Teaching Topical Material	Approved Self-study or Directed Study	Case Reviews or Grand Rounds	Formal Distance Learning	Journal Article Review	**Total Hours in Each Category**
Assessment Based Management										
Airway Management/Ventilation										
Emergency Pharmacology										
Trauma										
Medical										
Pediatrics										
Special Considerations										
EMS Systems										
Total hours in each venue:										**Grand Total**

SKILLS VERIFICATION

History Taking	
Medical Assessment and Management	Fracture Immobilization including traction splinting
Trauma Assessment and Management	Intravenous Therapy
Advanced Cardiac Arrest Management	Parenteral Drug Administration
Infant Resuscitation to include airway obstruction	CPR proficiency/AED awareness
Basic Airway Management to include bag-valve-mask and bag-valve tube ventilation	Spinal Immobilization seated and supine including application of the cervical collar
Advanced Airway Management to include endotracheal intubation	Obstetrics Delivery Procedures to include care of the newborn
Cardiac Rhythm Interpretation including the ability to correctly interpret oscilloscopic and hard copy electrocardiograms	Emergency Medical Systems Medical Communications involving voice and ECG telemetry communications procedures including actions during communications failures

Satisfactory Assurance of Knowledge and Skills:

As the Physician Medical Director for the above named ALS Agency, I attest to the competence of the applicant named on this form in all the *Assurance of Knowledge* and *Skills Proficiency* categories listed on this page and recommend recertification of this individual.

_____ _____ _____

Signature of Agency Physician Medical Director | Printed Name of Agency Physician Medical Director | Date